

§417.558 Emergency, urgently needed, and out-of-area services for which the HMO or CMP accepts responsibility.

(a) *Source of payment.* Either CMS or the HMO or CMP may pay a provider for emergency or urgently needed services or other covered out-of-area services for which the HMO or CMP accepts responsibility.

(b) *Limits on payment.* If the HMO or CMP pays, the payment amount may not exceed the amount that is allowable under part 412 or part 413 of this chapter.

(c) *Exception to limit on payment.* Payment in excess of the limit imposed by paragraph (b) of this section is allowable only if the HMO or CMP demonstrates to CMS's satisfaction that it is justified on the basis of advantages gained by the HMO or CMP, as set forth in §417.548.

[60 FR 46231, Sept. 6, 1995]

§417.560 Apportionment: Part B physician and supplier services.

(a) *Medical services furnished directly by the HMO or CMP.* The total allowable cost of Part B physician and supplier services furnished by employees or partners of the HMO or CMP or by a related entity of the HMO or CMP must be apportioned on the basis of the ratio of covered Part B services furnished to Medicare enrollees to total services furnished to all the HMO's or CMP's enrollees and nonenrolled patients. The HMO or CMP must use a method for reporting costs that is approved by CMS. CMS bases its approval on a finding that the method—

- (1) Results in an accurate and equitable allocation of allowable costs; and
- (2) Is justifiable from an administrative and cost efficiency standpoint.

(b) *Medical services furnished under arrangements made by the HMO or CMP.* When the HMO or CMP pays for Part B physician and supplier services on some basis other than fee-for-service, the reasonable cost the HMO or CMP pays under its financial arrangement with the physician or supplier must be apportioned between Medicare enrollees and others based on the ratio of covered services furnished to Medicare enrollees to the total services furnished to all enrollees and nonenrolled

patients. If apportionment on this basis would result in Medicare bearing the cost of furnishing services to individuals who are not Medicare enrollees, the Medicare share must be determined on another basis (approved by CMS) to ensure that Medicare pays only for services furnished to Medicare enrollees.

(c) *Medical services furnished under an arrangement that provides for the HMO or CMP to pay on a fee-for-service basis.* The Medicare share of the cost of Part B physician and supplier services furnished to Medicare enrollees under arrangements, and paid for by the HMO or CMP on a fee-for-service basis, is determined by multiplying the total amount for all such services by the ratio of charges for covered services furnished to Medicare enrollees to the total charges for all such services.

(d) *Emergency services, urgently needed services, and other covered medical services for which the HMO or CMP assumes financial responsibility.* The Medicare share of the cost of Part B emergency or urgently needed services or other Part B services that are not furnished by a provider and for which the HMO or CMP accepts financial responsibility is determined in accordance with paragraphs (b) and (c) of this section.

[50 FR 1346, Jan. 10, 1985, as amended at 58 FR 38082, July 15, 1993; 60 FR 34888, July 5, 1995]

§417.564 Apportionment and allocation of administrative and general costs.

(a) *Costs not directly associated with providing medical care.* Enrollment, marketing, and other administrative and general costs that benefit the total enrollment of the HMO or CMP and are not directly associated with furnishing medical care must be apportioned on the basis of a ratio of Medicare enrollees to the total HMO or CMP enrollment.

(b) *Costs significantly related to providing medical services.* (1) The following administrative and general costs, which bear a significant relationship to the services furnished, are not apportioned to Medicare directly; they must be allocated or distributed to the HMO